Date of Initial Request _____
For Agency Use Only

Medicaid Financial Application

for Supports Waiver Services

This application is only for persons **already** enrolled in Louisiana Medicaid.

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (list)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (list)* _____

1. Person Applying for Supports Waiver Services

Name (First, Middle Initial, Maiden, Last) _____

Social Security Number_____Date of Birth_____

Medicaid ID Number_____

Is the applicant married? ❑ Yes ❑ No

Home Address_____City_____

State_____Zip Code_____

Mailing Address (if different)_____City_____

State_____Zip Code_____

2. Person Who Handles the Applicant's Business Affairs

Name _____ Daytime Phone (_____)_____

Cell Phone (_____)_____E-mail Address _____

Mailing Address_____City_____

State_____Zip Code_____

Relationship to the Applicant _____

Does someone have power of attorney? ❑ Yes ❑ No

If **yes**, give their name and daytime phone number? _____

3. Income from Working

Does the applicant work? ❑ Yes ❑ No
*Send copies of **pay check stubs** or other proof of gross earnings from employer for **last month**.*

If **yes,** tell us name of employer and phone number._____

Gross Amount of Wages (before deductions)_____

How often paid? _____

For help with this application, go to a local Medicaid office or call 1-888-342-6207, TTY 1-800-220-5404.
The call is free.

4. Other Income

Does the applicant get any income other than SSI (Supplemental Security Income)? ❑ Yes ❑ No
*Send proof of this income. You **do not** have to send proof of Social Security.*

Where is the income from? _____

How much is received? _____ How often received? _____

5. Lump Sum of Money

Has the applicant received (or do they expect to receive) any lump sum of money like an insurance or lawsuit settlement, inheritance, or retroactive Social Security payment? ❑ Yes ❑ No

If **yes,** how much? $_____ When? _____

From whom? _____ For what reason? _____

6. Bank Accounts and Cash

Does the applicant have any bank accounts or cash? ❑ Yes ❑ No

How much cash did applicant have on hand the first day of the month? _____

What type of account does the applicant have? (pick one or more) ❑ Checking ❑ Savings ❑ CD ❑ None

Name of Bank or Financial Institution _____

Address of Bank or Financial Institution _____

Account Number _____ Balance on 1st Day of This Month $_____

Name(s) on the Bank Account _____

7. Trusts

Has the applicant ever created a trust, placed any items in trust, or been named as the beneficiary of a trust?
❑ Yes ❑ No *If yes, we will need a copy of the trust.*

8. Home and Property

Does the applicant own or are they buying the home in which they live and/or any other property? ❑ Yes ❑ No

If **yes**, give address or location and description of the property. _____

_____

_____

How much is the home and the property it is on worth? _____

9. Inherited Property

Does the applicant have a share in an undivided estate or heir property? ❑ Yes ❑ No

If **yes,** tell us about it on the next page.

Describe the Property_____

_____

Value of the Property $_____Amount Owed on the Property $_____

Number of Other Heirs _____

10. Property and Asset Transfers

Has the applicant or anyone acting on his behalf sold, given away, or signed over the ownership or deed to any assets or property? ❑ Yes ❑ No If **yes**, give the following information.

What was given away, sold, or signed over? _____

_____

_____

To whom?_____ Date _____

11. Health Insurance

Does the applicant have health insurance, including Medicare supplements, that cover doctor and hospital visits? ❑ Yes ❑ No If **yes**, give the following information. *Send copy of front and back of insurance cards.*

Name and Address of Company _____

Group/Policy Number _____Monthly Cost $_____

12. Life/Burial Insurance

Does the applicant have life and burial insurance with combined face value above $10,000? ❑ Yes ❑ No

If **yes**, amount? $_____ Name and Address of Companies_____

_____

_____Policy Numbers_____

Your Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF ME

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you on purpose give information that is not true OR if you on purpose do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFYING INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) changes in mailing or home address; 3) changes in health insurance and premiums; 4) changes in income; and 5) changes in things owned by anyone who gets Medicaid who is disabled or over age 64.
CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to.

WHAT I HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.
NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.
ESTATE RECOVERY RULES FOR THOSE GETTING MEDICAID SERVICES SUCH AS NURSING HOME, GROUP HOME, AND HOME AND COMMUNITY BASED SERVICES: You understand that Estate Recovery rules require the Department to recover the cost of certain Medicaid payments from the applicant's estate. These costs include the total amount of payments for facility services, hospital care, payments to HCBS or PACE providers, and prescription drugs received at age 55 or older. The estate is the property owned at the time of death. The Department will not make a claim against the estate while the applicant or his or her legal spouse is still living. The Department also will not make a claim if the applicant has a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if the heirs apply for a hardship waiver after the applicant's death. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or if there are other convincing situations.

 **Sign Your Name Here: _____ Date _____**

If someone working for Medicaid helped you fill out this form, they need to sign on the line below.

_____ Date _____

✓ Before you send this application, please check if you have done these things:

- ☐ **All questions and all sections have been answered.**
- ☐ **If the applicant is working, I am sending proof of income like copies of paycheck stubs. For all other income, I am sending copies of benefit checks or award letters.**
- ☐ **If the applicant has a trust, I am sending a copy of it.**
- ☐ **If the applicant has health insurance, I am sending a copy of the front and back of all insurance cards.**
- ☐ **The application has been signed and dated.**